Information

Role of the Ombudsman in the Modern Medical Center

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CONFLICT AND CONTROVERSY within medical centers have existed for years. A number of factors, however, have enhanced the potential for conflict and controversy and have made the characteristics of controversy more complex: the increasing complexity of health care, education and research; the growth within such institutions; the increasing competition for resources within the health care commons.

In the past, conflict was often implicitly (and arbitrarily) resolved on the basis of a firmly enforced hierarchical structure, and discussion of conflictual issues was often discouraged. In contrast, today controversy usually is tolerated if not encouraged and open, lively discussions of controversial issues are aired and encouraged by social forces. Consequently, there is a need for effective modes for resolving conflict within modern health centers.

This article describes, as an example of an approach to conflict resolution within a medical center, the development and implementation of the office of the Medical School Ombudsman at the Stanford University Medical Center. The ultimate goals of this office are the internal and informal resolution of conflicts and controversies within or among the various constituencies. We believe that this office has had a continuing, important, positive influence on our medical center and that our experience will be of interest and use to other medical communities.

The Concept of an Ombudsman

The concept of the ombudsman is not new. For example, ancient Roman society established a tribune as an official who resolved problems arising from the class structure of this society. The word ombudsman was derived from the Swedish word meaning "people's advocate." The concept of an ombudsman has been used effectively in 20th century industrial settings in a number of different ways. For instance, offices have been established to provide advice, counseling and resolution of disputes; these offices also play a role in handling issues such as disagreements about performance evaluations, complaints of discrimination, sexual harassment, pay inequity and unfair assignments. Obviously, there is some variability in the definition of the concept of an ombudsman and in the purposes to which the ombudsman is put. Nevertheless, an overriding theme emerges of a person who is concerned with hearing and investigating a wide range of conflictual issues. This person informs and assists others within a constituency and attempts to improve the working of an organization by a spectrum of methods including education, persuasion, arbitration and mediation. Moreover, an ombudsman serves an important function by assuming a neutral role because in many conflictual situations no other neutral person may be available.

The Stanford University Ombudsman's Office

Following the establishment of ombudsmen at a number of universities throughout the United States and elsewhere, Stanford University in 1970 established an Office of the University Ombudsman. The initial charge to the ombudsman (August 1973) stated,

> The Ombudsman's task is to protect the interests and rights of members of the Stanford Community from injustices or abuses of discretion, from gross inefficiency, from unnecessary delay and complication in administration of university rules and regulations, and from inconsistency, unfairness, unresponsiveness, and prejudice in the individual's experience with university activities. The Ombudsman exists to receive, examine and channel the complaints and grievances of members of the Stanford community, and to secure expeditious and impartial redress.

At the outset, it was decided that the ombudsman must be a faculty member of senior rank and widely perceived to be of ethical as well as academic stature, who possessed the administrative and interpersonal skills to take on the tasks of the ombudsman's office. Interestingly, the first university ombudsman chosen at Stanford University was a psychiatrist; other universities have chosen professors of humanities or natural or social sciences, clergymen or, in one case, a person with experience in labor relations. Despite the success of this first ombudsman in both establishing this office and carrying out its mandate, subsequent university ombudsmen have been neither psychiatrists nor physicians.

Even from the beginning the university ombudsman's office found itself being asked to resolve issues arising at the medical center. The medical center community consists of approximately 3,433 persons representing a broad range of backgrounds and interests. In particular, it is made up of undergraduates (approximately 100), graduate students (97), medical students (373), house staff (interns and residents, 427), postdoctoral fellows (418), faculty (547), academic staff (108) and nonacademic staff (1,343). The number of cases brought from the medical center to the university ombudsman was initially small, perhaps as a reflection of the administrative and geographic sequestration of the medical school at one end of campus. By 1980, however, it became clear that issues arising in the medical center were sufficiently frequent and complex as to warrant a separate and dedicated locus for resolution of conflict.

The Stanford Medical Center Ombudsman's Office

The Stanford University Medical Center Ombudsman's Office was formed in 1981. In establishing the office, the university built upon the strength and effectiveness of the

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university ombudsman's office and developed an extension of that office to be located within the medical center. It was decided that the characteristics necessary for an effective ombudsman's office included (1) independence from traditional departmental and administrative structures of the medical center, (2) familiarity with the administrative structure, as well as policies and procedures of the medical center, (3) expertise both in terms of well-established policies and procedures and in terms of handling less well-defined situations in which no firm policies exist or situations where policies were not effectively implemented, (4) access to information and (5) full authority to investigate, but no power to compel. A search committee, including representatives from the university and medical center administration, faculty, students, house staff and medical center staff, was convened and identified a number of qualified candidates. The first medical school ombudsman was an emeritus professor of medicine.

Constituencies

It was decided that the office would represent a broad set of constituents, including students, house staff, postdoctoral fellows, faculty and staff at the medical center (patients were, by design, not included in this group since they have a number of other advocates at the medical center). From the beginning, the office has been utilized and has proved to be a valuable resource to each of these groups. During the first 3¾ years there were 308 cases considered by the office. The breakdown of cases by constituency and by type is given in Table 1. Medical students had more contact with the office than any other single group. The common areas of concern among medical students centered around academic issues and teaching. Together, these two areas accounted for 47% of student contacts with the office. Financial concerns were also common among medical students. This trend was also seen among house staff: the most common area of concern for this group was academic issues.

Structure of the Office

By design the office itself has had a small staff and little need for fiscal and administrative support. The staff includes the ombudsman, his or her assistant and a small amount of clerical support. To date the ombudsman has been a senior member of the faculty appointed by the president of the university on a 25% basis. The assistant is appointed on a 50% basis. Both of these persons, however, serve in an "on-line capacity" with activities distributed throughout the week. It is interesting that a number of persons have chosen to begin a dialogue with the office outside of normal working hours. This may reflect urgency or the need for confidentiality in some cases, or the psychological overtone in others. A receptionist/typist provides clerical support to the office.

The office has been located in such a manner as, on the one hand, to be easily accessible to its constituencies and, on the other, to provide a setting in which openness and confidentiality can be maintained. Within the confines of our medical center, it was decided to house the office in a building adjacent to the main medical center—that is, away from the visibility of a section of the main medical center. This separation also reinforces the concept that the office is independent of other administrative entities—for example, the personnel office, the dean's office and the various departmental offices.

Issues

A remarkable range of issues have been brought to the office. In some cases the office is simply used as a source of information. For example, a worker or student new to the area may seek advice about housing, child care or other similar personal needs. In other cases, the office has served as a nodal point for communication. For instance, we have helped student groups identify appropriate entities within the medical center that are concerned with developing support for curricular or extracurricular activities, and have advised them of the most productive strategies in obtaining such support. In some cases, simply putting several interested parties in touch with each other has been of considerable value.

In some instances the office has played a major role merely by providing information about conflict resolution. Examples include referring grievants (or potential grievants) to specific administrative offices and informing them about proper grievance procedures. In other cases, explanation of a conflictual issue ("this is why you were not promoted") has led to resolution of the problem.

Other activities of the office have involved more direct involvement in conflictual issues. They have usually involved vertical interactions (such as involving a house officer and an attending physician; technician and supervisor; student and professor), but in some cases the problematic relationships have been lateral (student and student). The degree of conflict

TABLE 1.—*Constituencies*

Types of Issues	*Undergraduates*	*Graduate Students*	*Medical Students*	*House Staff*	*Postdoctoral Fellows*	*Faculty*	*Staff*	*Total*
Academic	3	3	35	24	7	8	2	82
Grading	2	1	3	...	...	...	...	6
Honor code		3	...	...	...	...	...	3
Teaching		...	10	3	...	1	1	15
Registration, credits/units	1	...	3	...	2	...	1	7
Housing	1	...	2	1	2	5	2	13
Financial/benefits		1	15	2	7	1	3	29
Student services/affairs		...	12	...	...	...	...	12
Faculty/academic affairs		1	1	5	3	20	2	32
Sexual harassment		...	...	2	1	1	3	7
Personnel/staff affairs		...	...	1	...	1	43	45
Miscellaneous	1	2	15	17	2	5	15	57
Total	8	11	96	55	24	42	72	308

has ranged considerably, from the incipient and seemingly minor interpersonal problems ("Mr Smith, who works at the desk next to mine, smokes. I like him a lot but the smoke bothers me. How do I tell him?") to active but resolvable problems ("My attending doesn't show up until 9:30. I'm enrolled in a seminar that begins at 10:00.") and to difficult interpersonal issues. Two examples follow.

- A medical center worker came to our office concerned about her supervisor; the worker felt that she was about to be fired. After discussing the issues of conflict with her and her supervisor, it became clear that she had great strengths in terms of technical skills but that she preferred to work alone and was not facile in interactions with other workers. The office in which she worked was a very busy one, with a need for an individual with good communication skills. On the other hand, this worker had excellent technical skills which were not being utilized. Relocation of the worker to another department resulted in a situation where her skills were needed and where she is making a substantial contribution. This arrangement allowed for the recruitment of an employee who better met the needs of the initial employer.
- A beginning house officer approached the ombudsman with numerous complaints about the chairman of his department. Indeed, the house officer had identified some important issues in the department but had never effectively communicated these to the chairman. After a number of counseling sessions with the ombudsman, the house officer entered into an effective and productive dialogue with his chairman. He subsequently progressed through the chief residency as an active and constructive member of the department and, together with the department chariman, has developed several new programs.

In other instances, conflict arises, not as a result of poor interactions between individual persons, but rather as a symptom of institutional disequilibrium. An example is provided by a resident who brought to the office a complaint about last-minute changes in his night call schedule and their impact on his family life. Examination of this issue showed that there had been a concatenation of schedule changes, illnesses and maternity leaves which had led to a situation in which indeed there was insufficient staffing for night call. Moreover, the department did not have the resources required for recruitment of the additional personnel required to correct this problem. As a result of this departmental issue, discussions were begun in the medical center and this was quickly identified as a key problem common to many departments. Most clinical services were already tightly organized with all residents, especially those in the early postgraduate years, working hard, long hours to complete their normal daily work, in addition to the extra burden resulting from periodic emergency changes in the night call schedule. Thus, in the case of unexpected absence of even one house officer, the remaining residents were called upon to increase their workloads considerably. This type of problem had become particularly acute when three residents in one department were absent simultaneously. Moreover, a number of residents felt that they could not be absent, even in instances of serious illness, because this would impose an additional hardship on fellow residents. The solution here involved bringing the problem to the attention of the chief of staff and the dean of the medical school. Once they became aware of the depth of the problem, they were able to allocate funds to finance alternative methods of temporary coverage.

Finally, some issues involve principles of due process. Here the ombudsman's office serves a very important function by simply insuring that due process is followed. The office has played an important role in the development of due process procedures per se. An example of this function arose from allegations of possible unethical behavior (and the implications of such behavior in terms of suitability for the practice of medicine) on the part of a medical student. Discussion showed that there had been poor communication between the student and a faculty member which led to a set of mutual misunderstandings between the two. Little basis existed for the serious charges, however. The questions of unethical behavior and of a need for possible disciplinary action were both resolved when the origin of the problem was understood. In fact, once the reasons for the situation came to light, both the student and faculty member learned from the experience. More significant for the institution as a whole was the discovery that due process procedures had not been established for handling this or similar situations. As an outgrowth of this case, the ombudsman's office recommended that the medical school establish a mechanism for due process that would include the protection provided students through the Stanford Judicial Council and incorporated in those recommended by the Association of American Medical Colleges. This led to the development of a set of guidelines and the establishment of a procedure whereby an ad hoc Committee on Suitability for the Practice of Medicine can be convened. The new protocol was published for the first time in the *Bulletin of the School of Medicine* for 1984-1985.

Modes of Resolution

The most important rule underlying mechanisms of resolution by the ombudsman is that there are no inflexible rules. The success of the ombudsman's office necessarily depends on resourcefulness and on the development of ad hoc solutions to a spectrum of problems. Nevertheless, a number of general principles underlie the operation of the office. By definition, the activities of the office are confidential. This is essential if members of the community are to interact with the office. As part of this confidentiality, our policy is not to contact the other parties involved in an issue unless the person seeking help agrees to this.

It is also clearly understood that the actions of the office result in *recommendations* rather than formal action. The informal nature of conflict resolution in itself fosters an atmosphere in which all of the involved parties are often willing to examine a broad spectrum of potential solutions to a given problem. Moreover, it has been important for the ombudsman's office to achieve recognition for clear *objectivity*. While the office serves a number of constituencies, it is clearly understood that the ombudsman's role is that of obtaining fair and equitable solutions and not that of acting as an advocate for any particular party. In this regard our experience has been that the issue can often be resolved without formal grievance actions if a potential grievant can be made aware of *both* sides of an issue.

The office has also found that the diversity of points of view within the medical center may provide considerable assistance in the resolution of conflict. We have often enlisted

(after obtaining permission from the involved parties) the help of relevant faculty, administration or other concerned parties. In many cases this provides an important resource. The critical point here is that it is often possible to develop a creative solution by identifying the many sides involved in an issue and by impartially thinking through the issues with *all* of the involved parties.

We have also found that specific issues ("the night call schedule is unfair") are often symptomatic of more general problems ("being a house officer is a stressful experience"). In view of this, after resolving specific issues our office has often turned its attention to generic problems after resolving specific issues. For example, as a result of problems arising out of issues such as night call schedule, a Committee on Housestaff Well-Being has been created and support groups for medical students have been established.

From Reactive to Proactive

In addition to specific problems, the examination of generic ones has been followed by a further evolution in the function of the office—that is, development of a proactive as well as reactive role. Thus, the office of ombudsman is now in a position to anticipate problems and to suggest changes in medical center structure or operation, or both, which will prevent their occurrence. We have found that an individual case often represents the tip of an iceberg. A single grievance may often reflect a more general problem about a particular committee, course or the like. Because of this, we have come to view the ombudsman's task as including the delineation of these more general problems. For example, the office is currently examining the general issue of financial debt incurred by medical students and house staff. Together with the financial aid office and other cognizant administrative offices, the ombudsman's office is exploring new mechanisms for providing financial assistance to medical students. Similarly, as noted above, the office of the ombudsman played a role in developing procedures whereby questions concerned with the suitability for the practice of medicine can be examined.

Conclusions

The ombudsman's office at Stanford University Medical Center has now existed for 4½ years. In this short period of time, it has become widely accepted and utilized by medical students, house staff, research fellows, staff and faculty. A large number of specific issues and a smaller but important set of general issues have been handled effectively by the office. Interestingly, the medical center community has come to appreciate that in conflictual situations, the action of the ombudsman can protect and provide help to all parties. As a result of this, members of the medical community have dealt in an increasingly open and candid way with the office. While requiring a significant investment of time and effort on the part of the ombudsman, the office has not been costly in other ways. Given the complex and potentially costly nature of the issues involved, the office of the ombudsman and the concept of an ombudsman have played a very successful role in resolving conflict and controversy at Stanford University Medical Center. We believe that this office can, in many ways, serve as a model for the development of similar entities in other medical communities.